the glands, one of which was in the inguinal glands. In 31 out of the 39 cases the recurrences were manifested during the first year, 5 during the second, 2 during the third, and 1 during the fourth. In 8 of the cases operated upon it was not possible to remove all of the growth, and 4 of these died as the immediate result of the operation, and 4 from recurrences. In addition to the 104 cases operated upon, Stande has had 52 cases of carcinoma of the cervix, 13 of which refused operation; the others were considered inoperable. Recurrences have not appeared on 17 out of 41 cases, or 41.5 per cent. under observation for five years or more since operation.

A New Method of Extirpating both Appendages.—O. Beuttner (*Zent. f. Gynäkol.*, 1908, xxxii, 1033) makes two transverse incisions in the fundus extending into the uterine cavity and including between them a wedge-shaped piece of the uterus with the insertion of both tubes and the attachment of one or both ovarian ligaments at the sides. This wedge-shaped piece is then divided in the median line and each appendage is liberated from the uterus outward, an ovary being left if possible. In this respect the method has the same advantages as that of Faure, in which the uterus is divided in the median line to the internal os and each half of the cervix amputated, the halves of the uterus and the appendages being then freed from within outward. In women still menstruating Beuttner, however, desires to retain the uterus and he finds, moreover, like Dührssen that this method of resecting the fundus has a very favorable effect in curing a chronic metritis.

A New Intraperitoneal Method of Shortening the Round Ligaments.—W. Latzko (*Zent. f. Gynäkol.*, 1908, xxxii, 1278) describes a method of shortening the round ligaments which he has employed in over 100 cases during a period of eight years, with no accidents and only exceptionally a recurrence of the retroversion. The round ligaments at points as remote from the uterus as possible are sutured to the fundus in the median line, and beginning at this point the loops of the round ligaments thus formed are sutured together by through-and-through sutures and to the uterus in the median line anteriorly. The loops are thus brought together as far toward the cervix as possible, below which point the two newly made folds of the broad ligaments are also sutured to the anterior wall of the uterus in order to prevent the entrance of a loop of intestine into the pocket otherwise formed.

Perforating Wounds of the Uterus Inflicted during the Course of Intrauterine Instrumentation.—Heineck (*Surg., Gyn., and Obst.*, 1908, vii, 424) believes pseudoperforation of the uterus though of exceptional occurrence, is a clinical condition and that spontaneous perforations of that organ, due to preëxisting pathological conditions of it, can and do occur. Heineck insists that perforating wounds of the uterus, whether intraperitoneal or extraperitoneal have a morbidity and a mortality—conditions which increase in direct ratio with the inexperience, the carelessness, the surgical ignorance, and the surgical uncleanliness of the operating surgeon. In the 154 tabulated cases 42 had a fatal ending. Of the 66 cases, in which expectant treatment was employed, 21 resulted fatally. Laparotomy, including apparently necessary intra-abdominal work, was performed seventy-two times. In this class 17 deaths are recorded and 3 unstated results. Vaginal hysterectomy was done fifteen times, resulting four times in death, and in one no result is given. Heineck expressly states that dilatation of the cervical canal and instrumental curettage of the uterine cavity are, owing to their associate dangers, not office operations. In these operations general anesthesia is advised and the following rules suggested: (1) Ample cervical dilatation during which the cervix should be steadied should be a preliminary step to uterine curettage. (2) Intra-uterine instrumental maneuvers should be attempted only by those (*a*) who are thoroughly conversant with modern surgical asepsis and antisepsis; (*b*) who are capable of recognizing malpositions of the uterus and pathological conditions of that and of neighboring organs; and (*c*) who are acquainted with the treatment of the dangers incident to the successive steps of the intra-uterine operation they are performing. Heineck advises once the uterus is perforated, suspension of all further intra-uterine instrumentation except careful removal of the uterine contents by a finger or, while the uterus is being watched through a laparotomy incision, with a curette. In 2 cases swabbed with carbolic acid death followed. Intra-uterine irrigation following such perforations are opposed. Vaginal hysterectomy is opposed. The conditions in uterine perforations indicating laparotomy are the presence of infection, large-sized or multiple perforations, the presence of coexisting vascular, omental, or intestinal lesions, and prolapse of viscera through the opening.

Primary Implantation of an Ovum in the Pelvic Peritoneum.—HIRST and KNIPE (*Surg., Gyn., and Obst.*, 1908, vii, 456) state that in order to substantiate the claim that there has been a primary implantation of an ovum in the peritoneum, the presence of the following conditions is necessary: (1) A normal condition of the tubes, ovaries, and broad ligaments, except where the ovum is implanted; (2) no penetrations of the intraligamentary space from the ovarian fimbria; (3) no intraligamentary rupture of the tube; (4) no escape of the ovum from the uterine cavity; (5) proof that the peritoneum constitutes the reflexa of the ovum. Galabin and Witthauer have each reported an authentic case of primary implantation of the ovum in the peritoneum, and Hirst and Knipe report a third that meets the requirements just mentioned. In passing, mention may be made of the inaccuracy of the first condition, as pathological conditions of the tubes, ovaries, or broad ligaments may coexist and even antedate such implantation.

The case of Hirst and Knipe is as follows: The patient, aged thirty-one years, had one child seven months ago after a normal labor and has had no other pregnancy. Her menses began at the age of fourteen years and have always been regular and normal; her family history was negative. Three months after the birth of her child, which she is nursing, menstruation recurred twice a month. During all the six days just preceding her admission to the hospital she flowed. On the sixth day while stooping over she was seized with pain in the lower part of the abdomen, very severe in character and producing faintness. Pain and syncope recurred six times during the evening. Operation was one March 27, 1907. Free blood in moderate quantity was found in Douglas' pouch. On the posterior surface of the left broad ligament